Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ROBERT KILIAN

Respondent Name
VIA METROPOLITAN TRANSIT

MFDR Tracking Number
M4-14-2402-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
April 04, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "If it is determined that a patient has reached MMI the Designated Doctor will charge $350.00 and will bill as 99456-W5. In addition to the $350.00 for MMI Assessment the Designated Doctor will charge $300.00 for the first area of examination and $150.00 for each additional area of examination. The areas of examination are defined as (1) spine/pelvis (2) upper extremities/hands (3) lower extremities/feet. Non musculoskeletal body areas shall be billed and reimbursed according to the testing required for the assignment of the impairment rating in addition to the $350.00 for the MMI assessment."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue is in regards to the reimbursement for the impairment rating of post-traumatic stress disorder (PTSD) billed under procedure code 99456WPW5.

According to 28 TAC §134.204(j)(4)(D)(i), the definition of non-musculoskeletal body areas are defined as body systems, body structures and mental behavioral disorders. Non-musculoskeletal body areas are to be billed and reimbursed using the appropriate CPT Code for the test required for the assignment of an impairment rating. Based on the above definition post traumatic stress disorder would be classified as a non-musculoskeletal body area. "

Response Submitted by: Argus Services Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 05, 2013	Impairment Rating Evaluation of a Musculoskeletal Body Area	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - W1A – Workers Compensation State Fee Schedule Adjustment * Reimbursement per Rule 134.203/134.204. Prior to March 1, 2008, Rule 134.202*

Issues

1. What is the applicable rule for determining reimbursement for the disputed services??
2. What is the total allowable amount for the impairment rating of the spine.
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute involves a Designated Doctor Impairment Rating (IR) evaluation of the cervical spine, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4)(C)(ii), which states that "The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area."
2. In order for the requestor to be reimbursed pursuant to rule §134.204(j)(4)(C)(ii)(I), the health care provider, in this case, was required to perform a full physical evaluation with diagnosis related estimate (DRE) of the cervical spine. Review of the submitted documentation finds that the spine was rated using a full physical evaluation with diagnosis related estimate method. The Division concludes that the impairment rating of the spine is allowed at $150.00 in accordance with the requirements of §134.204(j)(4)(C)(ii)(I).
3. The respondent issued payment in the amount of $150.00. Based upon the documentation submitted, no additional reimbursement is recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/20/14 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.